Dr. Mark McClellan's Remarks
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Thank you, Dr. John Gans (APhA CEO) for that introduction. It's a pleasure to be here with all of you. I also want to take a minute to thank a few other people who have worked closely with CMS staff over the past year, in particular: Susan Winckler, Kristina Lunner and Susan Bishop who helped tremendously as we finalized the drug benefit regulation, and Mitch Rothholz who has worked closely with CMS' Dallas region and central office on immunization issues. Our organizations are working together in so many ways now.

And I particularly want to thank all of you, America's pharmacists who are gathered here as part of APhA, for your work on the front lines of getting better and more affordable drugs to America's seniors. Your work educating beneficiaries made pharmacists the number one source of enrollment for the more than 6 and a half million beneficiaries in the Medicare drug discount card – a number that continues to grow steadily. And while this transitional program has helped millions of our most vulnerable beneficiaries save billions on the medications they need, we can provide far more help if we can keep working together. Over the next nine months, we need to make sure seniors are aware of Medicare's new drug coverage and then, in 2006 and beyond, that they get the best possible help in using that coverage. As with the drug card, we know how important – how essential – you all are to this critical public health goal.

We've been discussing prescription drug coverage and the Medicare law with APhA for quite a while, and it's made a big difference in helping us implement the law successfully. In fact, we are now seeing strong interest from health plans in providing drug coverage. We are going to provide the drug benefit on schedule, everywhere in the country, in just nine months. And building on this past work, it's important for you to stay involved and for us to take these next steps together, both because beneficiaries working with pharmacists that they know and trust is the best way to provide prescription drug assistance, and because, let's face it, the drug benefit will have an important impact for your pharmacies. I think we are on track for a really positive impact. Our latest estimates, based on detailed actuarial and economic analysis, are that the drug benefit will have a substantially positive financial impact, a net increase in pharmacy revenues of 0.6% to 1.9%. And that doesn't include additional positive impacts from high-quality medication therapy services, or of sales from increased foot traffic through the pharmacy.

But more importantly, the drug benefit has the potential to significantly enhance your role as an essential health care provider in Medicare – by helping you help seniors not only to afford their medicines, but also to find less costly alternative

drugs like generics to meet their needs, and to push forward further steps toward electronic systems that reduce administrative costs and errors.

Important as the drug benefit is, I want to first spend a few minutes talking about how the drug benefit is the linchpin of some broader changes taking place in Medicare and in our health care system as a result of the new Medicare law. The drug benefit itself is a tremendous step toward getting Medicare's benefits in line with modern medical care. For example, it makes no sense when it comes to patients with diabetes, for Medicare to pay for heart surgeries and limb amputations and dialysis but not the medicines and lifestyle counseling that have been proven to prevent the diabetes complications in the first place. You can't build a sustainable, 21st century Medicare program without coverage for prescription drugs. And even more importantly, the drugs mean a much better quality of life for the patient. But prescription drug coverage alone is only one step.

Through the drug benefit and through other changes happening right now in Medicare – like up-to-date coverage of preventive services, and new programs to help beneficiaries with chronic illnesses get better coordination and support in preventing complications, and better information on the quality and costs of care, and new support for electronic health systems, and new ways of paying for care that pay for better quality not simply more services – through many changes like these, we are using the Medicare law to create a Medicare program that provides new support and new financial rewards for prevention-oriented, personalized, up-to-date medical care. Medicare is changing from a passive program that pays for treatments for the complications of diseases, to a proactive program that helps pharmacists and other health professionals do what they can do best in 21st century medical care - keep our beneficiaries healthy. And that means a better health care system, with pharmacists playing a central role.

Make no mistake, these are truly fundamental changes in the way Medicare does business. And we know that they will not work without the support and involvement of pharmacists, who have long embraced the consumer-focused health care.

The close relationships that pharmacists have developed with many of the seniors in Medicare are critical for the success of these changes, and especially for the drug benefit. Most Medicare beneficiaries regularly use prescription drugs, and they frequently come into contact with their local pharmacist. Pharmacists are the logical, and the trusted source of information for Medicare beneficiaries about how they can get real help from Medicare's new coverage.

Because success with pharmacists is so integral to the success of our Medicare reforms, one of my top priorities has been to bring much more of pharmacist expertise and more of a voice for pharmacy into our agency. Of all the health professionals we've brought into CMS to help make sure we implement all of the

changes in the new Medicare law effectively, pharmacists have been at the top of the list. Since the new Medicare law took effect, we've hired at least one pharmacist in each of our 10 regional offices, like Denise Stanley from our Southeast Region, who's attending this conference. And we've added 10 more pharmacists in our central office, including pharmacists in senior leadership positions inside the Center for Beneficiary Choices, like Kim Caldwell, who until recently was on the Texas Board of Pharmacy. We've also hired Babette Edgar to head our formulary review process. Prior to her work at CMS, Babette spent nine years at AdvancePCS and simultaneously served as a Clinical Instructor at the University of Maryland. We've also got Craig Miner, a pharmacist and a lawyer, on board. And we've made arrangements to work with up to 125 additional pharmacists to take a close look at the features of the drug benefit like the drug formularies that have been proposed by the health plans that intend to offer Medicare drug coverage. And one of my own senior advisors, Larry Kocot, joined us from his senior leadership position at the National Association of Chain Drug Stores. He's overseeing many of these pharmacy-focused efforts, and he's here too, to make sure we're working together smoothly. Larry likes to joke that CMS is perpetuating America's pharmacist shortage by hiring all of the qualified ones we can find to work for us. And I want you all to know: we're still hiring.

I'm telling you about who we are to make a point. CMS is not the agency we used to be – we are increasing our expertise and our ability to support the work of health professionals with our beneficiaries to get the most out of our coverage and our health care system. And the #1 health professional priority, based not just on what we are saying but how we are acting, is pharmacists. You have the most voices – pharmacist voices - inside CMS in the history of Medicare. In our regional offices and our main offices in Baltimore and my very own office, you have a place to turn. And I want to challenge you all to make the most of these opportunities to improve Medicare and our health care system. This is essential, essential for our success in reforming Medicare.

And that brings me to the key barriers we need to overcome, now that we know that the drug coverage is going to be available everywhere, on schedule. Our estimates show that tens of millions Medicare beneficiaries will enroll in Medicare drug plans in the initial months of the drug benefit. And a recent Kaiser Family Foundation survey found that almost one-third of seniors said that they would "very likely turn" to their pharmacists for help with decisions about Medicare drug coverage. So we need to take steps to make sure those interactions you have with seniors about the drug benefit work. But we know pharmacists that at least two barriers stand in the way of providing the practical, personalized assistance that seniors expect from their pharmacists: time and information.

Working with you, we're going to do something about those key barriers to the success of the drug benefit. We're using the Medicare law to make significant changes that recognize the key role, the essential role you play in the health and well being of our beneficiaries. These changes will save pharmacists time – time

that we'd rather have you spend with patients. And we are also working to give you the information you need to educate beneficiaries to become informed consumers, in a form that is easy for you to use within the constraints of a busy pharmacy.

So I'd like to focus on three things today: what CMS is doing to support pharmacists under the new drug benefit; what we're doing to create more time for you to spend with patients; and what we're doing to provide you with the relevant and useful information you need to help beneficiaries get the most out of the new drug coverage.

First, and perhaps most importantly, we are using the new Medicare law to support and protect the critical role of pharmacists in providing care.

Our interactions with you and our own pharmacy experts have made clear how important it is for the success of the drug benefit for beneficiaries to continue to have access to the local pharmacists who they depend on. And so, although the new benefit will be administered through health plans, **the Medicare law and our regulations to implement the law create safeguards to ensure that beneficiaries have access to pharmacies that are conveniently located where they live and work, and where they can maintain the face-to-face relationships with their pharmacists.**

First, as you may know, the Medicare law requires that Medicare drug plans meet the TRICARE access standards for pharmacy networks for Department of Defense retirees all over the country. That means, in urban areas, 90% of covered patients must have a network pharmacy within 2 miles of where they live. For suburban patients, 90% must have a network pharmacy within 5 miles, and for rural beneficiaries, 70% must have access to a pharmacy within 15 miles. And we are encouraging broader networks than this, just as we did with the Medicare drug card. And while we also encourage plans to contract with non-community pharmacies, such as hospital and clinic and mail-order pharmacies, access requirements will only be satisfied with broad participation of community pharmacies. The new legislation also creates an "any willing provider" requirement for plans participating in the Medicare drug benefit program, and our rules require plans to offer a standard set of contract terms to any pharmacy.

Through our final regulation for the drug benefit, CMS has also addressed concerns about creating a "level playing field" for retail and mail-order pharmacies. Our final regulation on the drug benefit requires plans to give their enrollees the option of purchasing a 90-day extended supply of a covered Part D drug through a network retail pharmacy, rather than through a network mail-order pharmacy only. The law states that the beneficiary would be liable for any "differential in charge" resulting from obtaining the prescription from retail as opposed to mail order. To implement this, we have just released further guidance to provide a clear path for retail pharmacies to compete directly with

mail order pharmacies, leaving the decision about where to fill prescription where it should be: up to the beneficiary.

To get the most value from the drug benefit, we also want to reward and support the extensive knowledge and real world experience of retail pharmacists for assisting in coordinating and managing drug therapies. A key part of achieving this goal is the law's requirement that every Medicare drug plan have a program to ensure that prescription drugs are used appropriately, to improve outcomes and reduce adverse drug interactions. Pharmacists play a critical role in managing patients' medication needs, helping patients deal with chronic illnesses, and achieving better health outcomes by improving medication use and reducing the risk of adverse events such as drug interactions. Under the law, plans must implement a program of medication therapy management for certain high-risk beneficiaries, in particular, patients with high spending who take multiple drugs for multiple chronic diseases. Based on the initial results of a variety of medication therapy management programs, we are confident that medication therapy management programs, like other care coordination programs, will have increasing prominence in Medicare.

To speed the adoption of effective MTM programs, we want to find ways to identify and reward the most efficient and most effective pharmacy services. After all, the quality of pharmacy services really matters, just as does the quality of other health care services like nursing homes or hospital care. And the quality of pharmacy services can vary, just like the quality of those other services.

Just yesterday, I announced that we are starting to publish valid clinical quality measures for virtually every hospital in the country. And we are taking similar steps for nursing homes, and home health care, and dialysis providers, and we are working hard toward widely-available valid quality measures for physicians. These measures have a significant effect on how our beneficiaries choose their care, and they result in greater emphasis in our health care system on quality improvement. We want to do the same kind of thing for pharmacy care – to recognize and then to reward high-quality pharmacy services. To do this, it is very important to find ways to measure the quality of pharmacy services. And because these approaches to measure and reward quality only work when health professionals and other stakeholders are involved, we need to work with you to develop these measures. This is a critical and urgent piece of our overall cultural shift in Medicare and Medicaid toward promoting consumer-oriented, personalized care.

Along with our safeguards to assure that all of our beneficiaries have access to local retail pharmacists on a level playing field in the new drug benefit, **the second big thing I want to talk to you about is what we're doing to save you time** – time that you need to provide counseling and assistance to patients.

You know the studies that have shown that pharmacists spend at least 25% of their time handling basic insurance functions, like when beneficiary doesn't have their health plan information or know who to bill. That's not an efficient. You can't afford this anymore, and neither can we. But thanks to the new Medicare law, we've got an opportunity to implement new technologies to increase the speed, ease, and accuracy of identifying insurance coverage and filling prescriptions and determining payments. These systems, which build on the systems that pharmacists have helped develop and adopt in recent years, have made pharmacies one of the most wired and electronically efficient parts of our health care system. And we want to build on them to create an environment to allow you to do more to help our beneficiaries get more out of the new drug coverage.

Currently, you waste thousands of hours calling patients' employers and insurance companies to obtain information about benefits. Well, we're going to change that. For one thing, the Medicare law mandated standard benefit ID cards. Plan sponsors will be required to issue a standard benefit ID card for enrollees when the benefit takes effect in 2006. But we also know that beneficiaries may forget about their cards, so we're working hard to implement systems for pharmacists to get the information they need even when a beneficiary shows up knowing nothing more than their name and date of birth and Medicare number.

Through a collaborative public-private process, we've developed a new Coordination of Benefits system that is designed with one purpose in mind: to make sure that pharmacists don't have to be insurance clerks as well as critical health care providers. We've worked diligently with pharmacists, State Pharmacy Assistance Programs, health plans, States, PBMs, drug manufacturers and our other partners and stakeholders to develop a near real-time coordinated benefits system for determining eligibility and coverage and out-of-pocket drug costs for beneficiaries. This COB system will play a critical role in the electronic exchange of information between CMS and payers, to ensure that beneficiaries get all their available coverage when out-of-pocket costs are charged at the pharmacy. This is important, because the Medicare coverage is designed to work with other sources of coverage like assistance from states and employers – and these transactions need to happen automatically.

The result will be a system that will enable pharmacies and plans to process a beneficiary's prescriptions smoothly, even for that beneficiary who shows up at the pharmacy counter next January and doesn't even remember his drug plan's name. And, the system will enable plans to inform beneficiaries as to when they have reached certain coverage limits, and when they can expect even greater financial relief in the case of catastrophic coverage, and how much they can save with a generic version of their medicine. They will have their claims processed correctly, without the need for bringing in receipts or extra cards or submitting other documentation if they have wraparound coverage.

This system will help smooth the transition for beneficiaries and avoid extra time and effort for pharmacies, with the opportunity for some of the productivity gain in pharmacies to be invested in time spent helping beneficiaries get the most out of the benefit.

But that's not the only environmental change we're making. We simply we cannot become a 21st century health care system while providers exchange clinical information using 19th century instruments – pen and paper – augmented by a 20th century technology – overused fax machines to move these paper records around every time they're needed. The Medicare law also gives us the authorities and opportunity to take advantage of effective technologies that should be used now to change this.

The Medicare law requires us to move to e-prescribing. The benefits are obvious. E-prescribing can improve patient safety, quality of care, and administrative efficiencies for physicians and pharmacies. With e-prescribing, pharmacists and other health professionals can get more support in getting the most appropriate, least costly drug for every patient. This will facilitate better decisions about prescription drugs, and that means more for our money in the drug benefit. The law requires that drug plans participating in the new prescription drug benefit support electronic prescribing, and it requires widespread implementation of e-prescribing no later than 2009.

Well, we're going to accelerate that schedule. We recently published a proposed rule to establish foundation standards for e-prescribing. These proposed standards were developed through an extensive public process conducted by the National Center for Vital and Health Statistics, based on electronic standards already in widespread use. And we're going to finalize this rule so that the standards are operational before the drug benefit begins in 2006.

We're also going to implement a follow-on set of higher-level clinical standards be implemented after they have been sufficiently pilot tested. To make this happen, we intend to award a set of e-prescribing pilot projects to be implemented in conjunction with the drug benefit in January 2006. Many of you are involved in e-prescribing now, and we want you to work with us as we identify and implement the pilots. And we'll support expansions of the successful e-prescribing pilots as quickly as possible.

So, we're building on the existing progress toward electronic health care in pharmacies to ensure the real-time, up-to-date exchange of information to help you better serve you patients.

With the drug benefit starting in January, and with these new support systems coming into place to help you concentrate on helping seniors with their drug needs, we need to make sure that you have clear information about the drug benefit to share with your patients.

Again, while we're on track and on schedule to deliver this new coverage everywhere, providing these new prevention-oriented benefits isn't enough. We need to make sure that seniors are aware of the drug benefit and get the support they need to be confident about their decision to use it to lower their costs. Right now, our focus is on awareness.

We want to make sure everyone knows the key facts about what is coming. **Enrollment begins on November 15th.** The first enrollment period runs **through May 15, 2006.** Although enrollment is voluntary, **seniors will pay less if they enroll on time.** It's just like homeowners insurance or life insurance – you pay more if you wait.

The drug coverage will be available to help everyone with Medicare, regardless of their incomes, regardless of whether they get fee-for-service Medicare or a Medicare Advantage plan – plans that are also more widely available and that provide more opportunities for saving through coordinated care including pharmacy care than ever before – and regardless of how they now pay for drugs. **Medicare's new coverage will help seniors pay for the prescriptions they need.** Medicare's coverage is help with brand-name and generic drugs. And as I've discussed, seniors can get these savings at a retail pharmacy that's convenient for them.

For people with lower incomes, the message is: If you're just living off their Social Security check, you can get even more help. **Medicare's new prescription drug coverage will help all seniors pay for needed prescriptions, but it offers *significant extra help* to beneficiaries with low incomes.**

We worked out this clear, basic information with input from many of you, and from many other groups, because clear and simple information like this is just critical right now. Again, our main task right now is awareness - not all seniors know about the drug benefit, and many mistakenly think it's not a benefit for them.

When you talk about the drug benefit, you may want to share not just these basic points but some of the numbers, because the savings will be significant. When our coverage takes effect in 2006, a typical person with Medicare would see Medicare's new coverage pick up more than half of his or her total drug spending, or nearly $1,300. And if an illness or injury drives the beneficiary's drug costs over $3,600 per year – Medicare will cover 95% of that bill. Medicare will provide help with drug costs and protection against very high drug costs for all seniors.

And as I said, there is truly comprehensive help for seniors who are struggling between paying for their drugs and for other basic necessities. Seniors who are eligible for Medicare and Medicaid, and those who have incomes are below 135 percent of the federal poverty level and limited financial assets – that's an income

for a couple of around $18,000 – they will get a Medicare drug benefit that includes no premiums or deductibles whatsoever, no gaps, and copays of just a few dollars. On average, Medicare will be paying over 95 percent of their drug costs. That's a drug benefit worth well over $4,000. And this coverage isn't available only to a few: almost a third of our beneficiaries are eligible. And some extra help is also available for beneficiaries with higher assets and incomes up to 150 percent of the poverty level.

To make sure that all beneficiaries can take advantage of the new assistance that's available to them, it helps to think of beneficiaries as falling into **four main groups** that need different kinds of information and support.

The first group is beneficiaries who have drug coverage now and are satisfied with it, including beneficiaries with retiree coverage and beneficiaries in Medicare Advantage plans. If you have good coverage you like from an employer or Medicare Advantage, Medicare can provide new assistance with the cost of that coverage. You don't need to change plans to get more help with the costs of your drug coverage starting next year. For these beneficiaries, we're working with their employer or union plan, or with their Medicare Advantage plan, to make sure they get the new help and that they know its coming.

The second group is the "full dual eligible" beneficiaries who are eligible for both Medicare and Medicaid and who currently get their drug coverage through Medicaid. For these beneficiaries, we are starting early. We are getting information from states now, so that we can start notifying these beneficiaries and their caregivers about what's coming. And we will these dual-eligible beneficiaries know in October about the drug plan to which they've been assigned, if they don't choose a plan on their own. That will provide almost three months for planning any specific transition. And we've also issued a new guidance that plans must follow, which requires widely used best practices for any medication transitions around this move – typically, providing coverage of a patient's current drug over a transition period to make sure the transition goes smoothly, or following equivalent best practices. And we've also made clear that states can fill 90-day prescriptions in December and collect the usual Federal Medicaid match, in effect extending the transition period even further. We will be working closely with all of you who are involved in long-term care and other special settings to implement this transition effectively.

A third important group of beneficiaries are those with low incomes who are not on Medicaid drug coverage. We are working closely with the Social Security Administration, the Administration on Aging, and most importantly, and many non-governmental organizations who have been collaborating with us on the drug card to help reach these low-income beneficiaries.

Many millions of beneficiaries qualify for the comprehensive low-income subsidy. But I want to emphasize, **enrollment for this low-income assistance is not**

necessarily automatic, unless we know who the beneficiaries are. We can identify many of them, such as those with so-called SLMB or QMB benefits, the limited Medicaid benefits, and get them into the comprehensive coverage. But there are millions more beneficiaries who may qualify, and we need to reach out to them to help them complete and submit the subsidy application. So we're taking new steps to do that. For example, to simplify the low-income subsidy application as much as possible, the drafts have been tested in focus groups and have been subjected to special cognitive testing, and we've obtained comments from many outside groups. The resulting application is only six pages in large type and no financial documents are required. Filling it out is some work, but it compares very favorably with every other enrollment form for means-tested health benefits. For comparison, the SSI application runs to 28 pages, Medicaid applications are generally 20 or more pages and require financial records, and so forth. This form can be filled out with just a little bit of reviewing your liquid assets and income. It amounts to about $600 worth of drug benefits per page, because the low-income drug coverage in Medicare is so comprehensive. So this is easier than it's ever been by far to get means-tested extra help, but it's going to be some work.

And that's why we are starting early. Applications for the low-income subsidy starting in mid-May, right away. The Social Security Administration will be sending out about 20 million letters to potentially eligible beneficiaries. The idea is to have the maximum amount of time possible to identify low-income beneficiaries and get them enrolled. And once we identify these beneficiaries through the applications, we will get them into comprehensive coverage, even if they don't choose a drug plan on their own. You can help by making sure that any of your beneficiaries with limited incomes, living just on a Social Security Check with below about $13,000 income for a single and $18,000 for a couple, know to send in the application starting in June. Even if they can only do part, that's ok, we can follow up and help with the rest. The main thing is, get the low-income subsidy application in to Social Security as soon as possible this year.

And that brings me to the large and important fourth group: beneficiaries with relatively higher incomes and assets who don't have adequate coverage today. We need to make sure these seniors know that the new drug benefit will be available to them, and that they can get specific information on how they can enroll starting this fall to save money and get more financial security.

In October is when they'll be able to hear about specific Medicare drug coverage options in their area. Like being able to save a lot of money compared to buying Medigap drug coverage on their own now, because the new Medicare coverage comes with a 75 percent subsidy and it never runs out. Like being able to cut their drug costs in half if they have typical drug spending and no coverage now, and being able to save even more if they have high expenditures. And if they are lucky enough not to spend much on drugs now, they will be able to get the best deal – a better deal than waiting – on coverage that will give them the security of

protection if their drug needs get higher. That's what insurance is about – 30 percent of seniors who enroll in Part B each year spend less than they pay in premiums, and we expect the number to be even smaller with the drug coverage – an even larger proportion of seniors will see the coverage pay off in the first year, and everyone who enrolls will get real protection.

And they'll also hear about the option of getting drug coverage and even more extra benefits from the Medicare Advantage plans – plans that now save beneficiaries more than $100 a month on average compared to enrolling in traditional Medicare either alone or with a Medigap plan, and that save even more for beneficiaries with chronic illnesses. These plans are particularly important opportunities for pharmacists. We are targeting the increased funding for Medicare Advantage on beneficiaries with chronic illnesses and high costs – exactly the beneficiaries who have the most to gain in terms of lower costs and better outcomes from more generous drug coverage and high-quality pharmacy services to avoid costly medical complications. My sense is that the Medicare Advantage plans recognize this opportunity and want to work with pharmacists to deliver better coordinated care together. Medicare Advantage plans will be more widely available than ever this year, and even better options will be available next year.

Medicare's new benefits will provide important new help with drug costs for seniors who enroll. For this to happen, seniors need to have to **good information** about their choices, and **good advice** they can count on, if they want it. Or in some cases they – or maybe their family members or caregivers – need **help to choose and help to enroll**, so they can get the savings**.**

We have a lot of partners in this effort to help seniors save with the new coverage – and that includes partners right here, right now at the APhA annual conference. On Monday, APhA is joining with Medicare Today to bring about 400 seniors to the conference for the one-on-one benefit consultation sessions and health screenings and check-ups. And while the seniors benefit from the free services, pharmacists who participate will be learning how to host this type of event, so that they can conduct similar events for senior groups when they get back home. This is the kind of personalized outreach that we really need from our partners and stakeholders to make the drug benefit a success. So thank you – I can't express how truly grateful I am for your commitment to helping America's seniors.

These local events and patient outreach involving pharmacists are an important part of our major, national grassroots education campaign. We are undertaking this campaign with broad support from inside and outside the Federal government. Our regional offices around the country are fully engaged to collaborate with local Social Security offices and other local partners in this grassroots effort. We have doubled our support for state health insurance assistance programs across the nation. We're working closely with the

Administration on Aging to provide outreach and support through local Area Associations on Aging and their affiliates.

And we're working with many partners outside of government, including coalitions including Medicare Today, spearheaded by the Healthcare Leadership Council, in addition to other partners like the Access to Benefits Coalition and the National Council of Organizations on Aging. We're also getting help from financial planners, and online health programs like WebMD.

And of course, we're also developing a comprehensive campaign to reach out to pharmacists with detailed and consistent information about the drug benefit, and to include interested pharmacists in our outreach programs. Our campaign will involve the leadership of national pharmacy organizations like APhA to leverage experience, reach, and resources to develop a consolidated pharmacist education plan. I'll talk more about this in a minute.

As this campaign moves later this year from making people aware to helping people enroll and start saving, there are also going to be many options for supporting confident decisions. Our toll-free phone line,1-800-MEDICARE, is available 24 hours a day, seven days a week, with customer assistance in Spanish as well. We continuously test the responsiveness and accuracy of our assistants on our drug programs, and they are consistently scoring well over 90 percent. And all the information that we provide on the phone is also available through our website, medicare.gov, which has been upgraded and enhanced for ease of use based on your input. We are currently testing Prescription Drug Plan Compare tools, which will be available in the fall with specific information on drug prices and pharmacies and benefits that can be personalized to our beneficiaries' needs.

These web-based resources are useful not only for web-savvy seniors and their family members. We've established links between these resources and the websites developed by other organizations that offer additional support for seniors, like the AARP, and to the web resources used by organizations that assist beneficiaries in getting help with their drug costs – for example, the website accesstobenefits.org helps volunteers and advocates enroll seniors in the drug card and other assistance programs. The tools will have available in the fall will be integrated with support for seniors and their family members provided by these partners, as well as with personal health record programs like Web MD, and with support provided by financial planners or health professionals or insurance agents.

With all of these steps, we can help far more Medicare beneficiaries get much more assistance with their drug costs than ever before. We are going to deliver the drug benefit on time, we are going to make seniors aware, and then we are going to focus on helping seniors actually lower their medical costs significantly.

Enrollment is the bottom line, because that's what leads to lower drug costs. Awareness now, then assistance, then enrollment starting later this year.

I'm particularly pleased that we can already count on APhA as a leading partner. Earlier, I mentioned the pharmacist education campaign. This is important. As part of this campaign, APhA is leading the way, and has agreed to partner with CMS to develop and operate a nationwide continuing education program with the goal of helping pharmacists be effective sources of information and support about the new Medicare coverage. It's worth learning about: 40 percent of all prescriptions and a larger share of prescriptions in retail pharmacy go to our beneficiaries. Although still in preliminary planning stages, this train-the-trainer program is the result of collaboration between APhA and CMS under the leadership of Greg Dill, a terrific pharmacist from our Chicago Regional Office. Ideally, the program will contain both federal and state-specific material to provide a complete program for practicing pharmacists who will need to understand how to implement the law in the state(s) in which they practice and educate their patients about available options.

The goals of the train-the-trainer program include:

1. Provide pharmacists with the resources and materials necessary to understand the Medicare Prescription Drug Benefit, so that they can transfer key information to their Medicare patients and other pharmacists and pharmacy staff.

2. Help beneficiaries understand the program by ensuring that they receive accurate information, so that they are able to make wise decisions.

3. Help pharmacist colleagues with the new program, by providing them with accurate information to implement the program and answer their and their patients' questions.

4. Offer pharmacists an opportunity to earn continuing education credits while they become effective counselors in this important new dimension of pharmacy care, while they educate other pharmacy practitioners of offer continuing education to colleagues, all while they maintain and strengthen relationships with Medicare beneficiaries.

After successfully completing a series of basic requirements, participants would be qualified as Medicare Prescription Drug Benefit Pharmacist Trainers. These Trainers will return to their practice sites and communities, to educate other pharmacists on the benefit. They will help provide educational materials for use in their community, and they will be able to offer practicing pharmacists continuing education credits in a second round of training meetings.

This program is being designed while keeping in mind on the one hand the pressures and limitations on pharmacists today, while recognizing on the other hand that the Medicare benefit will unquestionably have important impacts on pharmacy services, and effective training on key issues will help make sure that impact is as positive as possible. The goal is to advance pharmacy practice by ensuring Medicare beneficiaries understand the Prescription Drug Benefit, and establishing the key role of the pharmacist as a source of information and support for their Medicare patients. That would mean another reason for positive perceptions of local pharmacists as the trusted source when it comes to guidance about drugs. Working together, we can make sure that this collaborative educational program will help both the pharmacists in their relationships with patients and the Medicare program by empowering pharmacist providers to help beneficiaries get the most out of the drug benefit.

In addition to the help on education and training, I really appreciate the time you've given me this morning to talk about some of the things we're doing to improve Medicare. There's a lot more I didn't get to cover here, but that's ok, because we will be doing a lot more work together. We will continue to build on our successful collaboration so far, and will keep working closely with you at all levels in CMS on implementing Medicare's new benefits.

We have some unprecedented opportunities, unique opportunities right now to make changes in Medicare that will encourage affordable, prevention-oriented, personalized, high-quality care and that gives patients the information and support they need to be educated health care consumers.
And that's why I'm so glad APhA is doing so much to take the lead, providing the expert partnership we need for the effective delivery of new pharmacy benefits. We face some real challenges. But I'm confident we will meet them, together, to bring longer life and better health through affordable, modern health care to every one of our citizens.

Thank you.

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